APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT

State Form 9237 (R4 / 1-03)
Approved by State Board of Accounts, 2003

Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204
(317) 234-2060
www.in.gov/hpb

APPLICANT

Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

☆ ***Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.***

FOR OFFICE USE ONLY	
DATE RECEIVED	**FEE INFORMATION**
	Fee received:
	Receipt number:
	Application number:
	Certificate number issued:
	Date issued:

TO BE COMPLETED BY THE APPLICANT *(PLEASE PRINT CLEARLY IN INK)*

Name *(last, first, middle, maiden or previous)*

Address *(number, street or rural route)*

City, state, ZIP code

Social Security number ☆	Date of birth *(month, day, year)*	Place of birth

Telephone number *(daytime)*	Email address

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?

☐ Yes ☐ No

BASIS FOR CERTIFICATION

☐ Endorsement ☐ Examination Date taking NCCPA examination: _____

PHYSICIAN ASSISTANT DIPLOMA GRANTED BY

Name of school	Date of graduation *(month, day, year)*

Address of school *(number, street, rural route, city, state and ZIP code)*

NCCPA CERTIFICATE

Certificate number	Date granted *(month, day, year)*	Date of expiration *(month, day, year)*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS

Continued on the next page.

If your answer is **"yes"** to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1.	Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
2.	Have you ever been denied a license, certificate, registration or permit to practice as a physician assistant or any regulated health occupation in any state *(including Indiana)* or country?	☐ Yes ☐ No
3.	Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
4.	Have you ever been charged with drug addiction or alcohol problem?	☐ Yes ☐ No
5.	Have you ever been convicted, pled guilty, or *nolo contendere to:*	☐ Yes ☐ No
	A. A violation of any Federal, State, or local law relating to the use, manfacturing, distribution or dispensing of controlled substances or drug addiction ?	
	B. Any offense, misdemeanor or felony in any state ? *(Except for minor violations of traffic laws resulting in fines.)*	☐ Yes ☐ No
6.	Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7.	Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8.	Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes ☐ No

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM PHYSICIAN ASSISTANT SCHOOL

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalities of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for certification as a Physician Assistant.

I hereby release the aforementioned persons, firms officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to the same.

Signature of applicant	Date signed *(month, day, year)*

Continued on the next page.

SUPERVISING PHYSICIAN'S STATEMENT

Name of Supervising Physician *(last, first, middle, maiden)*	Social security number *
License number	Date license expires *(month, day, year)*
Residence address *(number, street, rural route, city, state, and ZIP code)*	
Office address *(number, street, rural route, city, state, and ZIP code)*	
Residence telephone number	Office telephone number
Date of birth *(month, day, year)*	Place of birth

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of school	Location	Date of graduation

POST GRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING

INSTRUCTIONS: *Include* ***all*** *internships, residencies and / or fellowships in the United States or Canada.*

NAME OF SCHOOL / HOSPITAL	LOCATION	FROM *(MO / YR.)*	TO *(MO / YR.)*

INSTRUCTIONS: *Give a description of your practice, areas of specialization, and / or board certification.*

JOB DESCRIPTION FOR THE PHYSICIAN ASSISTANT

INSTRUCTIONS: *ON AN ATTACHED SHEET, give a description of the exact privileges and tasks the physician assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the physician assistant's performance. THIS JOB DESCRIPTION MUST BE ON COMPANY LETTERHEAD AND BE SIGNED BY BOTH THE PHYSICIAN ASSISTANT AND THE SUPERVISING PHYSICIAN.*

LIMIT ON PHYSICIAN ASSISTANT SUPERVISION

As a supervising physician, I understand that I may supervise no more than two (2) physician assistants. Please indicate below the name and certificate number of the physician assistant(s) you are currently supervising, if any.

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the physician assistant named in this application will be under your continuous supervision in accordance with IC 25-27.5-6 and 844 IAC 2.2, and that you shall review all records of patient encounters maintained by the physician assistant within 24 hours after the physician assistant has seen a patient and at all times retain professional and legal responsibility for the care rendered by the physician assistant.

Signature of supervising physician	Date *(month, day, year)*

Continued on the next page.

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of supervising physician	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned, requested by the Bureau, or any of its authorized representatives in connection with processing my application for supervising physician.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of supervising physician	Date *(month, day, year)*